

Dermatology Specialists

PATIENT INFORMATION					
Patient's Last Name:		First:	Middle:	Gender:	Marital status (circle one)
				<input type="checkbox"/> Male <input type="checkbox"/> Female	Single / Mar / Div / Sep / Wid
Is this your legal name?	If not, what is your legal name?		Date of Birth:	Age:	Social Security #
<input type="checkbox"/> Yes <input type="checkbox"/> No			/ /		
Preferred Language:		Ethnicity:	Please Circle Hispanic \ Non-Hispanic		Race:
Street address:		City:	State:	Zip Code:	
Please check best contact phone number below:					
<input type="checkbox"/> Home Phone: ()		<input type="checkbox"/> Work Phone: ()		<input type="checkbox"/> Cell Phone: ()	
Please list any patients of Dermatology Specialists that you are related to:					
Patients employment status:		Employer:	Employer Phone:		
Active \ Retired \ Student					
Occupation:					
Chose clinic because/Referred to clinic by (please check one box):			<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Internet <input type="checkbox"/> Ad <input type="checkbox"/> Physician <input type="checkbox"/> Insurance Plan Name: _____		
Referred By: (If physician, please provide phone number)			Physician's Number: ()		
Primary Care Physician:			Physician's Number: ()		
Name of Emergency Contact:		Relation to Patient:	Home Phone: ()	Cell Phone: ()	

INSURANCE INFORMATION					
Policy Holder's Name:		Date of Birth:	Social Security #:		
		/ /			
Insurance name:	<input type="checkbox"/> Check if address of policy holder is the same as above. If not, please provide the complete address below:				
Patient's relationship to policy holder:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Policy holder's employment status:	Employer:	Employer Phone:			
Active \ Retired \ Student		()			
Secondary Policy/Policy Holder's Name:		Date of Birth:	Social Security #:		
		/ /			
Insurance name:	<input type="checkbox"/> Check if address of policy holder is the same as above. If not, please provide the complete address below:				
Patient's relationship to policy holder:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Policy holder's employment status:	Employer:	Employer Phone:			
Active \ Retired \ Student		()			

List your email address below to gain access to your Personal Medical Portal via our website. You will be able to update your information, requests prescription refill, request appointments, and contact our medical staff.

Email Address: _____ Check box to decline email communication

Our office participates in electronic submission of lab work, pathology and prescriptions. This system allows us to submit prescription during your visit in our office. Please list the pharmacy below where we can send your prescription.

Pharmacy Name: _____ Location: _____

Patient/Parent Signature: _____ Date: _____